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NEOPLASTIC WOUNDS: SOCIO-DEMOGRAPHIC, CLINICAL AND THERAPEUTIC PROFILE OF PATIENTS WITH SKIN CANCER

FERIDAS NEOPLÁSICAS: PERFIL SOCIODEMOGRÁFICO, CLÍNICO E TERAPÊUTICO DE PACIENTES COM CÂNCER DE PELE

HERIDAS NEOPLÁSICAS: PERFIL SOCIODEMOGRÁFICO, CLÍNICO Y TERAPÉUTICO DE PACIENTES CON CÁNCER DE PIEL

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ABSTRACT

Objective: to describe the socio-demographic, clinical and therapeutic profile of patients with neoplastic wounds due to skin cancer. **Method:** this is a descriptive, documental, retrospective study with a quantitative approach, obtained through 431 medical records of a hospital, using an adapted script. The data collected were stored in the Microsoft Word program and analyzed by descriptive statistics. **Results:** there was a higher incidence of neoplastic wounds in 2015 (27.1%), most participants were men (54.0%), aged 60 years old or over (65.0%), farmers (23.2% %) and retirees (43.2%). The squamous cell histological type was prominent in 176 (40.8%) participants. **Conclusion:** the results show the lack of systematization of nursing care related to neoplastic skin wounds in the institution of the research. **Descriptors:** Nursing; Medical Records Department, Hospital; Skin Neoplasms.

RESUMO

Objetivo: traçar o perfil sociodemográfico, clínico e terapêutico de pacientes com feridas neoplásicas, decorrentes do câncer de pele. **Método:** estudo descritivo, documental, retrospectivo, com abordagem quantitativa, obtido por meio de 431 prontuários de um hospital, utilizando-se um roteiro adaptado. Os dados coletados foram armazenados no programa Microsoft Word e analisados pela estatística descritiva. **Resultados:** houve maior ocorrência de feridas neoplásicas em 2015 (27,1%); a maioria dos participantes era homens (54,0%), com idade igual ou superior a 60 anos (65,0%), agricultores (23,2%) e aposentados (43,2%). O tipo histológico espinocelular se sobressaiu em 176 (40,8%) participantes. **Conclusão:** os resultados mostram a falta de sistematização da assistência de enfermagem relacionada às feridas neoplásicas de pele na instituição lócus da pesquisa. **Descritores:** Enfermagem; Serviço Hospitalar de Registros Médicos; Neoplasias Cutâneas.

RESUMEN

Objetivo: trazar el perfil sociodemográfico, clínico y terapéutico de pacientes con heridas neoplásicas, decurrentes del cáncer de piel. **Método:** estudio descriptivo, documental, retrospectivo con enfoque cuantitativo, obtenido por medio de 431 registros de un hospital, utilizándose una guía adaptado. Los datos recogidos fueron almacenados en el programa Microsoft Word y analizados por la estadística descriptiva. **Resultados:** hubo mayor ocurrencia de heridas neoplásicas en 2015 (27,1%), la mayoría de los participantes eran hombres (54,0%), con edad igual o superior a 60 años (65,0%), agricultores (23,2%) y jubilados (43,2%). El tipo histológico espinocelular se sobresalieron en 176 (40,8%) participantes. **Conclusión:** los resultados muestran la falta de sistematización de la asistencia de enfermería relacionada a las heridas neoplásicas de piel en la institución de la investigación. **Descriptores:** Enfermería; Servicio de Registros Médicos en Hospital; Neoplasias Cutáneas.

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INTRODUCTION

The incidence of cancer has increased in the last decades and the disease is characterized as an important public health problem in Brazil and in the world, being the second cause of death in Brazil.¹

According to the National Cancer Institute (INCA)², the estimate for 2016 and 2017 in Brazil is the occurrence of approximately 600 thousand new cases of cancer, including cases of non-melanoma skin, reinforcing the magnitude of the problem of cancer in the country. Non-melanoma skin cancer (182,000 new cases) will be the most incident in the Brazilian population, followed by prostate (61,000), female breast (57,000), colon and rectum (34,000), trachea, bronchus and lung (28 thousand), stomach (20 thousand) and cervix (15 thousand). For these same years, it is estimated that 47,520 new cases of neoplasm occur in men and 51,540 in women in the Northeast region.² In Paraíba, it is estimated that there will be 8,250 new cases of cancer, and 2,030,000 new cases of cancer of the non-melanoma skin.

Although there is no data demonstrating the incidence of neoplastic wounds, a survey can be made of the estimated population with cancer. Therefore, it is estimated that 5% to 10% of cancer patients develop wounds, either due to primary tumor or metastatic tumors, especially in the last 12 to 6 months of life.³

It is emphasized that neoplastic wounds are formed by the infiltration of malignant tumor cells into the skin structures, leading to the consequent breakage of their integrity, with subsequent formation of an evolutionarily exophytic wound resulting from the uncontrolled cell proliferation that the oncogenesis process causes.⁴

It is noteworthy that there are several lineages of cutaneous neoplasms, being classified as non-melanoma, formed by basal cell carcinoma, responsible for 70% of the diagnoses; epidermoid or squamous cell carcinoma, representing 25% of the cases; and melanoma, encompassing all tumors that originate in melanocytes. Non-melanoma skin cancer has a higher

occurrence, but is less aggressive, having therapeutic possibilities of cure when diagnosed early. On the other hand, melanoma has a lower incidence, representing only 3% of the malignant neoplasms of the organ. However, it has a high possibility of metastasis. According to the Mortality Information System (2013), 1,547 people of the 6,230 new cases of melanoma skin cancer estimated for 2012/2013 died, 903 were men and 644 were women.⁵⁻⁶

These wounds that affect the skin constitute a further problem in the life of cancer patients, because they progressively become friable, painful, exudative, with a foul smell, and can disfigure the body and cause a self-image and psychological disturbance in the patient, as well as feeling of helplessness, humiliation, social isolation and sadness.⁷⁻⁸

It is understood that care with neoplastic wounds is not well established by the increase in its incidence in patients with cancer. Therefore, it is of paramount importance that nurses should be aware of the specific products, substances, coverages and medications best suited to control signs and symptoms, the economic reality of the patient and his/her relatives and the institution in which he/she is hospitalized to better intervene.⁹

In this perspective, the motivation for the topic arose from the scarcity of studies that contributed improving the quality of care provided, since scientific research addressing epidemiological, descriptive, clinical and therapeutic data of patients with neoplastic wounds is incipient in Brazil.

The following question emerged to deepen the knowledge about the subject: What is the socio-demographic, clinical and therapeutic profile of patients with neoplastic wounds due to skin cancer, assisted at a referral hospital in Paraíba? This questioning represented the starting point for the development of the research, considering that there is a need to know the patient in which various forms of care are provided and guide their care.

OBJECTIVE

- To describe the socio-demographic, clinical and therapeutic profile of patients with neoplastic wounds due to skin cancer.

METHOD

This is a retrospective and descriptive documentary study, with a quantitative approach, where secondary data extracted from medical records of cancer patients from the Medical and Statistical Archive Service of a referral hospital in Paraíba were used.

Data collection was performed from August 2015 to April 2016, where 8,360 records of cancer patients were analyzed. After reading these, 431 medical records were identified that met the inclusion and exclusion criteria, constituting the final sample of the study, being of the intentional type.

In this perspective, the inclusion criteria adopted were records of patients aged 18 years old or older who had a diagnosis of skin cancer, independent of the stage of the disease, with the presence of some neoplastic (exophytic) wound, in the time interval from 2009 to 2015. This range is justified because the first publication of the Manual for Care of Tumor Wounds was dated from 2007. From this perspective, at least a minimum interval of two years was considered for the manual having the country's public service network. As an exclusion criterion, there were medical records used that filled out data with unreadable or blank letters.

For data collection, a script adapted from Freire's study (2013), and INCA's Manual (2011) was used, addressing recommendations about the control of signs and symptoms of tumor wounds. At

the end of the collection, the data were transferred to the Microsoft Word program, arranged in tables, and then the descriptive analysis of the study variables was performed.

The research project was approved by the Research Ethics Committee under CAAE Number 42918715.1.0000.5182 and obeyed the ethical recommendations set forth in the guidelines and regulatory norms for research involving human beings, established through Resolution 466/2012 of the National Health Council, in Validity in the country, as well as the ethical observations in the Code of Ethics of Nursing Professionals - Resolution Number 311/2007 of the Federal Nursing Council (COFEN), Chapter III, which addresses the responsibilities, duties and prohibitions related to teaching, research and technical-scientific production.

RESULTS AND DISCUSSION

There were 8,360 people assisted at the hospital of the research for diagnosis and treatment of cancer between the years 2009 and 2015. The final sample consisted of 431 records of people who progressed with neoplastic wounds, where a higher incidence was observed (27.1%) in 2015. As to the socio-demographic profile, presented in Table 1, there was a predominance of men (54.0%) in the age group equal or greater than 60 years (65.0%), Caucasian (32.3%), married (27.6%), with one to three children (19.5%), without education (29.9%), farmers (23.2%) and retirees (43.2%).

Table 1. Distribution of people with neoplastic skin wounds assisted from January 2009 to December 2015, according to gender, age, race, marital status, number of children, education, profession and occupation. Campina Grande (PB), Brazil, 2016.

Variables	n	%
Year		
2009	40	9.3
2010	33	7.7
2011	53	12.3
2012	52	12.1
2013	53	12.3
2014	83	19.2
2015	117	27.1
Gender		
Male	231	54.0
Female	200	46.0
Age		
18 - 19	1	0.2
20 - 59	150	34.8
≥ 60	280	65.0
Race		
Caucasian	139	32.3
Yellow	28	6.5
Brown	138	32.0
Black	25	5.8
Not specified	101	23.4
Marital status		
Single	35	8.1
Married	119	27.6
Widow	57	13.2
Separated	2	0.5
Divorced	11	2.6
Not specified	207	48.0
Number of children		
None	17	3.9
01 to 03	84	19.5
04 to 05	33	7.7
More than 05	62	14.4
Not specified	235	54.5
Education		
Without education	129	29.9
Incomplete elementary school	72	16.7
Complete elementary school	24	5.6
Complete High school	11	2.6
Complete higher education	4	0.9
Not specified	191	44.3
Profession		
Farmer	100	23.2
Others*	75	17.4
Not specified	256	59.4
Occupation		
Employed	15	3.4
Retired	186	43.2
Self-employed	2	0.5
Not specified	228	52.9
Total	431	100

*The scientific parsimony in the variable profession was used since there was a stratification of multiple professional categories.

Observing Table 1, there was an expressive increase over the years, in which there was a greater occurrence (22.1%) of neoplastic wounds in patients diagnosed with skin cancer. According to the INCA, the estimate for 2014, which was also valid for 2015, pointed to an increase in the occurrence of cancer, with approximately 576 thousand new cases, including those of non-melanoma skin, reinforcing the magnitude of the cancer problem in the country and coming in line with this study.²

Regarding the gender, it was noticed that most of them (54%) were male. This circumstance can be explained by the fact that squamous cell carcinoma (SCC), a histological type of non-melanoma skin cancer, has been prominent among the study participants, occurring more frequently in men. It should be noted that the incidence of SCC in men is almost double that in women. It is postulated that the man is more at risk of developing it due to greater occupational and recreational exposure to the sun. It is

worth noting that, according to the 2014 and 2015 estimates, a total of 182,130 new cases of non-melanoma skin cancer were expected, with 98,420 cases in men and 83,710 in women. These values are an estimated risk of 100.75 new cases per 100,000 men and 82.24 per 100,000 women.¹

Concerning the age, there was a prevalence of neoplastic wounds in elderly patients (65%). International and national studies found that cancer patients with neoplastic wounds had a mean age of 60 years old, showing that neoplastic wounds is a present and growing complication in the advanced age ranges.¹⁰⁻¹¹

Regarding their race, 139 (32.3%) of the patients were Caucasian and 138 (32%) were brown. According to the relevant literature, 12 people with fair skin have decreased melanin, whose purpose is to protect the DNA of skin cells from UVA and UVB radiation.

Regarding marital status, 207 (48%) were not specified due to the incomplete completion of the revised medical records. However, 119 (27.6%) of those with neoplastic wounds were married. This data is of great relevance since the partner plays an important role in the adjustment to the diagnosis and treatment of the disease.

In the number of children, most (54.5%) of the medical records did not have registered information. However, 84 patients (19.5%) had between 1 (one) and 3 (three) children. Therefore, it is necessary to emphasize the need for health institutions to properly record patient information since this information is important and contributes to the quality of care and research.

The contribution of the children to the improvement of the quality of life and well-being of the elderly with cancer is related to several aspects, such as the care with hygiene, specific feeding, medication, dressings, as well as manifestations of love, affection and

solidarity. Finally, family support in caring for the person with neoplastic wounds contributes significantly to the development of the physical, emotional and social well-being of the person suffering from the disease and injury.¹³

As to the education, 191 (44.3%) medical records did not have this information. However, 129 patients (29.9%) were not enrolled, followed by 72 (16.7%) with incomplete elementary education.

A survey of patients with neoplastic wounds treated at the Hospital do Câncer de Pernambuco revealed that most patients (47.1%) had incomplete elementary education, followed by the illiterate variable (39.2%). In this sense, it is worth mentioning that the tumor wound arises in advanced processes of carcinogenesis, having a strong association with poor knowledge of the patient.¹¹

Regarding the profession, it can be seen that 256 (59.4%) of the medical records did not specify the occupation of the study participants and 100 (23.2%) patients were farmers.

A study carried out by rural workers pointed out that agricultural activities expose workers to conditions that favor the development of skin cancer, that is, exposure to ultraviolet solar radiation and pesticide application, in agreement with this study.¹⁴

Also, regarding the occupation, 228 (52.9%) of the medical records did not contain this information. However, 186 (43.2%) of the patients were retired. This circumstance can be explained by the fact that most of the sample is made up of elderly people.

Table 2 provides the clinical data of the pathology of patients with neoplastic wounds. When analyzed, it was found that the most frequent histological type of skin cancer was squamous cell carcinoma corresponding to 40.8% of the sample, followed by basal cell carcinoma with 38.7%.

Table 2. Distribution of people with neoplastic skin wounds treated from January 2009 to December 2015, according to the clinical variables of the pathology: histological type of skin cancer, time of diagnosis, extent of disease, number of associated diseases, risk factors, number of signs and symptoms, number of organs and/or systems affected, recurrence and clinical outcome. Campina Grande (PB), Brazil, 2016.

Variables	n	%
Histological types of cancer		
Basal Cell Carcinoma (BCC)	167	38.7
Spinocellular Carcinoma (SCC)	176	40.8
BCC + SCC	12	2.8
Melanoma	37	8.6
Others	39	9.1
Diagnostic time		
Less than 06 months	291	67.5
06 to 12 months	55	12.8
More than 12 months	85	19.7
Disease extension		
Local Tumor	354	82.1
Regional dissemination	66	15.3
Distant spread	11	2.6
Associated diseases		
An	18	4.2
Multiple	9	2.1
Not specified	404	93.7
Risk factors		
Exposure to UVA and UVB rays	115	26.7
History of cancer in the family	107	24.8
Not specified	209	48.5
Signals and symptoms		
One	13	3.0
Multiple	12	2.8
Not specified	406	94.2
Recidivism		
Yes	59	13.7
No	17	3.9
Not specified	355	82.4
Clinical Outcome		
High	1	0.2
Death	1	0.2
Not specified	429	99.6
Total	431	100

SCC is the second most common type of skin cancer, being overcome only by BCC. However, its incidence has increased in recent years, with an estimated of 3 to 10% per year. It is worth noting that this incidence is higher in the elderly and in the male, with a ratio of 3:1, which may justify the findings of this study.¹⁵

Regarding the time of diagnosis, 291 (67.5%) patients were diagnosed with skin cancer in less than six months until the beginning of treatment; and the local tumor predominated, being present in 354 patients (82.1%). These data are probably due to the faster search for medical help by patients, since Law Number 12,732 of November 2012 guarantees patients with malignant neoplasm the right to the first treatment in the Unified Health System (SUS) in a period of less or equal to 60 days after the diagnosis was confirmed.¹⁶

Regarding the associated diseases, 404 (93.7%) of the medical records did not have this information. However, 18 (4.2%)

patients had at least one cancer-associated comorbidity, where systemic arterial hypertension (SAH) prevailed in 11 of the 18 patients.

It is imperative to emphasize that the presence of comorbidities can be explained by the fact that cancer is a disease compromising and debilitating the patient in a wide variety of ways. Authors¹⁷ state that hypertension is the most frequently observed comorbidity in cancer patients, and its incidence increases with chemotherapeutic treatment, mainly with the use of angiogenesis inhibitors, which corroborates the findings of this study.

As the risk factors, 209 (48.5%) medical records did not specify this information. However, it was identified that 115 (26.7%) patients were frequently exposed to ultraviolet radiation.

Sun exposure is the main risk factor for the development of skin cancer. UVA radiation penetrates deeply into the skin

and is primarily responsible for photoaging and skin cancer. It is worth mentioning that levels of exposure to ultraviolet radiation are related to both individual characteristics and environmental factors, including skin type and phenotype, family history of skin cancer and cumulative level of exposure throughout life.¹⁸

Concerning signs and symptoms, 406 (94.2%) medical records did not present this information. However, 22 (5.1%) patients had multiple symptoms due to cancer. It should be emphasized that pain, nausea, vomiting, diarrhea, asthenia and weight loss were the most significant among the most prevalent signs and symptoms in this study.

It is worth mentioning that pain may be related to tumor pressure against adjacent structures, nerve damage caused by tumor enlargement and extension, edema resulting from decreased capillary permeability, exposure of nerve endings of the skin, infections, and removal of coverages, especially those that adhere to the fragile surface of the lesion. Nausea, vomiting, and diarrhea are related to the chemotherapy treatment and are considered unpleasant by the patients, constituting as determinants in the fall of

the quality of life related to the treatment. Also, asthenia and weight loss result from protein catabolism due to its own illness, intensive treatments and also human suffering.¹⁹

Regarding the recurrence of cancer, 355 (82.4%) medical records did not specify this data. However, there was relapse in 59 (13.7%) patients. Authors affirm that tumor size is directly related to the risk of relapse, being a predictor factor²⁰. Other studies²¹ have shown that the occurrence of metastasis and relapse are directly related to the decrease in survival and worse prognosis of the patient's condition.

As far as the clinical outcome is concerned, 429 (99.7%) revised medical records did not have this data properly specified due to the incomplete filling.

Table 3 highlights the clinical profile of neoplastic skin wounds present in patients. When analyzing it, it was observed that in relation to the clinical aspect of the lesion, the predominance was superficial ulceration, in 69 (16.0%) patients.

Table 3. Distribution of people with neoplastic skin wounds treated from January 2009 to December 2015, according to the clinical variables of the lesion: lesion aspect, tissue type, signs and symptoms, mutilations. Campina Grande (PB), Brazil, 2016.

Variables	n	%
Aspect of injury		
Surface nodule	11	2.6
Deep nodule	10	2.3
Ulcerated nodule	12	2.8
Surface ulceration	69	16.0
Infiltrating ulceration	53	12.3
Vegetative ulceration	35	8.1
Multinodular	1	0.2
Not specified	240	55.7
Signals and symptoms		
Pain		
Yes	41	9.5
Not specified	390	90.5
Odor		
Yes	10	2.3
Not specified	421	97.7
Bleeding		
Yes	17	3.9
Not specified	414	96.1
Exudate		
Yes	6	1.4
Not specified	425	98.6
Signs of Infection		
Yes	1	0.2
No	2	0.5
Not specified	428	99.3
Total	431	100

From the clinical point of view, the neoplastic lesions can be classified into nodular, ulcerated and vegetative. The nodular lesions are characterized by being covered by normal mucosa, able to be benign or malignant. The ulcerated lesions are divided into superficial when located parallel to the epithelium and infiltrating, when it invades the underlying tissues. Also, when it comes to vegetation, these are characterized by exteriorization and therefore are termed exophytic. In this perspective, superficial ulceration may have emerged among the others, because SCC, a predominant histological type in the sample, is manifested in squamous cells, which make up most of the superficial layers of the skin.²²

Regarding the signs and symptoms of the lesions, it was observed in this study that there was underreporting of pain, odor, bleeding, exudate and signs of infection, since most of the medical records did not have information about these data.

As for pain, it was observed that only 41 (9.5%) of the records had pain register. In neoplastic wounds, local pain is related to neuropathy, which is caused by nerve compression or invasion of structures by tumor growth, cleaning of the lesions and frequent dressing changes.²³

As the odor, only 10 of the 431 charts analyzed (2.3%) had this record. It should be noted that the fetid odor in neoplastic wounds occurs due to the formation of aggregates of necrotic tumor mass at the site of injury, in which aerobic and, mainly, anaerobic microorganisms colonize and infect the wound. As a consequence of this process, there is release of volatile fatty acids, such as acetic and caproic acid, as well as putrescine and cadaverine gases.⁷

It is noteworthy that besides to provoking in the patient with oncological disease a feeling of anger and, consequently, social isolation, humiliation and anguish, this symptom can trigger

nausea and vomiting and consequently lead to a nutritional depletion, leaving him in a state of significant physical weakness.²⁴

Regarding bleeding, 414 (3.9%) medical records did not specify this data. However, it was observed that 17 (3.9%) patients presented bleeding. It should be noted that bleeding in the lesion is related to some factors such as angiogenesis, rupture of capillaries and vessels, due to the infiltration of tumor cells in these vessels and thrombocytopenia. Consequently, hemostasis of the blood, lymph, and the cellular and interstitial environment is interrupted, making friable the tissue of the oncological wound.²³

Regarding exudate, only six of the 431 charts analyzed (1.4%) presented this data. The presence of exudate in the lesion bed is common during the inflammatory process. However, excessive levels can have detrimental effects. In oncological wounds, the exudate results from infectious processes resulting from the liquefaction of necrotic tissue and consequently the activation of the proteases by the bacteria that colonize the lesion, as well as the fact that the tumor is hyperpermeable to fibrinogen and plasma.²³

Concerning the signs of infection in the wound, only the registry of this symptom was observed in three records, in which one (0.2%) had this symptom and the other two (0.5%) mentioned the absence of this symptom.

It is worth mentioning that infectious episodes are generally related to the reduction of the immune response, the proliferation of anaerobic microorganisms and devitalized tissue in the neoplastic wound, which can trigger systemic and local signs, such as fever, odor, pain, exudation, wound bed coloring and inflammation.¹⁰

Table 4 shows the therapeutic modalities used by patients with neoplastic skin wounds.

Table 3. Distribution of people with neoplastic skin wounds treated from January 2009 to December 2015, according to the clinical variables of the lesion: lesion aspect, tissue type, signs and symptoms, mutilations. Campina Grande (PB), Brazil, 2016.

Variables	n	%
Aspect of injury		
Surface nodule	11	2.6
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Odor		
Yes	10	2.3
Not specified	421	97.7
Bleeding		
Yes	17	3.9
Not specified	414	96.1
Exudate		
Yes	6	1.4
Not specified	425	98.6
Signs of Infection		
Yes	1	0.2
No	2	0.5
Not specified	428	99.3
Total	431	100

It was observed that in the surgical procedure, the biopsy was prominent in 209 (48.5%) patients. Biopsy has been one of the diagnostic modalities used confirming the diagnostic hypothesis, collected at the time of the consultation, and usually concludes the diagnosis of malignant or benign neoplasms.

Skin biopsy consists of removing a small amount of tissue using techniques that preserve the lesion and so the potential thickness of the cancer and its margin can be examined carefully. After removal, the tissue is sent for pathological examination.²⁵

Regarding radiotherapy, 220 (51.0%) of the medical records had no records on this data, followed by 121 (28.1%) patients, who had not performed the procedure. However, it is worth mentioning that 30 (7.0%) patients had performed more than 30 radiotherapy sessions.

Radiotherapy is a therapeutic modality that can be used in conjunction with chemotherapy, surgery or bone marrow transplantation, capable of destroying tumor cells, since electromagnetic or corpuscular ionizing radiation when interacting with tissues causes water hydrolysis and rupture of the DNA chains, leading to reduction of the lesion, tumor,

bleeding, exudation, pain and odor. It is estimated that approximately 50% of patients with cancer disease should receive radiation therapy alone or as an adjunct to surgical treatment.²⁶

In the chemotherapy, 385 (89.3%) medical records did not have this information due to the inadequate filling. However, 46 (10.7%) patients were receiving chemotherapy.

Chemotherapy consists of the use of continuously or intermittently administered chemical compounds, varying according to therapeutic schemes, whose main function is to eliminate the malignant cells that form the tumor, reducing it and improving the symptoms. It is worth mentioning that chemotherapy drugs act in a systemic way, that is, in which drugs act indiscriminately in normal or cancerous cells, producing very unpleasant and compromising adverse effects.²⁷

Regarding the drug treatment of pain, 423 (98.1%) medical records did not specify the medicines used by the patients for their relief. Only eight of the records (1.9%) carried this information and six of them (1.4%) used non-opioid/anti-inflammatory analgesics, and two (0.5%) used strong opioids.

The World Health Organization has developed a specific method of classification of pain and medications that should be used according to their intensity to guide health professionals in the correct management of the relief of this symptom. The Pain Analgesic Stairway (EAD) standardizes the analgesic treatment of this symptom based on a four-step ladder according to the intensity of pain that the patient presents and verbalizes.

In the first step, pharmacological treatment is directed to mild pain, where non-opioid analgesics and non-steroidal anti-inflammatory drugs are used. When there is no pain relief, it is considered moderate, and it is inserted in the second degree of the scale. In this case, a weak opioid is added. If this combination is refractory, the pain is classified as intense and on the scale, it is allocated in the third step. Therefore, the weak opioid should be replaced by a strong opioid. Also, when pain is characterized as excruciating, interventional procedures such as anesthetic blocks and surgical procedures are recommended. It should be noted that only one drug in each category should be used at one time and that adjuvant drugs should be associated with all steps of the scale, according to specific indications.²⁸

It is imperative to highlight that when analyzing the data of the research it was explicit that the pain felt by the patients is not treated according to their intensity, since for the intense pain, the professionals used drugs recommended for the first step of the pain analgesic scale, such as dipyrone, tylex and paracetamol. For mild and moderate pain, there were records of medications such as morphine. Therefore, that pain is not evaluated in most patients, as presented in Table 3, and when assessed, the therapeutic conduction is undervalued by health professionals.

Concerning the products used in wounds, 100% of the medical records did not specify this information. In this perspective, it is worth emphasizing that the care of the neoplastic lesions follow the same precepts of the ideal dressing. However, these lesions have peculiar

characteristics (profuse exudate, putrid odor, pain, bleeding, pruritus), which must be considered from the beginning of treatment to provide comfort and quality of life.²⁹

In view of the data presented, it is necessary to mention the urgent need for health institutions to properly record patient information, since these data are important and contribute to the quality of care and research.

Undoubtedly, the registration of the care provided to patients is essential, given that the medical record serves as a means of communication among the members of the multi-professional team and consequently enables the continuity of care. Also, the registry of care and interventions contributes to the construction of epidemiological bulletins, provides data for research and legal proceedings and the health professional will be legally supported in their professional practice.

CONCLUSION

This study allowed to describe the socio-demographic, clinical and therapeutic profile of patients with neoplastic wounds due to skin cancer assisted at a referral hospital in Paraíba, being a relevant study, because it adds knowledge about the reality of people living with neoplastic wounds, their epidemiological and clinical management aspects of these lesions.

The shortage of scientific productions in this area was highlighted as a limitation of this study, as well as the fragility of nursing records, especially regarding the evaluation and clinical management of neoplastic wounds, impeding a broader analysis of care provided, once the registry includes subjective and objective information of the patient, constituting one of the most important indicators of the quality of care provided. In this perspective, it is imperative to emphasize the need to insert, effectively, permanent education in health services, so discussion spaces with professionals, especially nurses, are implemented on the importance and quality of medical records.

Also, it is necessary to invest in early detection and educational measures, encouraging and guiding the use of personal protective equipment against skin cancer, as well as a greater clinical commitment in performing a physical examination.

Therefore, it is believed that this initiative to include permanent education and educational measures can contribute to the development of nurses' skills and abilities in early recognition of risky lesions, as well as to evaluate and treat neoplastic skin wounds guaranteeing comprehensive care improving the quality of life of patients with cancer disease and, consequently, their family.

It is hoped that this study can contribute to the scientific and care community, enriching the database and arouses the interest for the development of new studies in this scope, because in this way, it will be possible to know the patients assisted with greater property and to identify if the care provided in different contexts are being satisfactory to these people suffering from oncological lesions.

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